

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

163-039134
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 304

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF
1 <u>0147</u>						
2 <u>0147</u>						
3						
4 <u>3</u>						
5 <u>2</u>						
6						
7 <u>0</u>						
8 <u>2</u>						
9 <u>9331X</u>						
10						
11						
12 <u>90-0</u>						
13 <u>1-0</u>						
ITEM NO.	SHOULD READ					

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Callaway</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>at Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u> c. CITY OR TOWN <u>Fulton</u> d. STREET ADDRESS (If outside, give location) <u>221 East 6th</u>	
3. NAME OF DECEASED (Type or print) First <u>Mrs. Mable</u> Middle <u>Luciel</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>October</u> Day <u>16</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 197-66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>laborer</u>	
11a. FATHER'S NAME <u>unk</u>		11b. MOTHER'S MAIDEN NAME <u>Mary Cato</u>	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no.</u>		12b. SOCIAL SECURITY NO. <u>Paul Richmond, Fulton, Missouri</u>	
13. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>1944</u> to <u>Death</u> and last saw her alive on <u>9-10-63</u> Death occurred at <u>9304</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John J. Brown M.D.</u>		22b. ADDRESS <u>Fulton, Mo.</u>	
22c. DATE SIGNED <u>10-18-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>October 20, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Southside Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Fulton, Missouri</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Geoffrey L. Lunn, Fulton, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 19-1963</u>	
26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>			

(Licensed Embalmer's Statement on Reverse Side)

JUL 28 1964

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4220

P. O. Address See Back Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.